The Informing & Care Coordination Handbook

A Guide for Working with Families

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Iowa Department of Public Health
EPSDT Informing and Care Coordination Handbook
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Chapter 1 Overview of Iowa's EPSDT *Care for Kids* program

Introduction

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provides comprehensive health care for Medicaid eligible clients[1] under the age of 21. According to the federal Centers for Medicare and Medicaid Services (CMS) there are two important features of the EPSDT program: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid clients use these resources.

The purpose of this handbook is to guide Title V Agencies in helping Medicaid clients effectively use these resources through informing and care coordination services. This handbook should be used in conjunction with the following resources.

- The IDPH **Maternal and Child Health Services Administrative Manual**. This manual is available on the IDPH website at http://www.idph.state.ia.us/hpcdp/common/pdf/family_health/mch_manual.pdf
- The **Medicaid Screening Center Provider Manual**. This manual is located on the Department of Human Services website at http://dhs.iowa.gov/sites/default/files/scenter_0.pdf
- The **CAReS User Manual**. This manual provides guidelines for documentation of EPSDT services. It is available on the IDPH website at http://www.idph.state.ia.us/hpcdp/common/pdf/CARES_Manual.pdf

The EPSDT Benefit

The Early and Periodic Screening, Diagnosis and Treatment program was implemented in 1967 by the United States Congress. The EPSDT benefit includes the following services:

1. **Screening through comprehensive well-child exams**. Schedules for periodic screening (known as the *Iowa Recommendations for Scheduling Care for Kids Screenings* or "periodicity schedule") of medical (including physical and mental health), dental, vision, and hearing are provided at intervals that meet reasonable standards of medical practice.

CMS rules require that the EPSDT screening include all of the following services:

- Comprehensive health and developmental history including screening of both physical and mental health development

[1] The term 'Client' will be used throughout the EPSDT Informing and Care Coordination Handbook to include the child and young adults age 0-21 years eligible for Medicaid, and parents, foster parents, guardians or other family member's responsible for the care of an eligible child 0-17 years of age. The term 'Client' also includes 19-20 year olds enrolled in the Iowa Health and Wellness Plan, Title V or Medicaid.

- Comprehensive unclothed physical exam
- Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP)
- Laboratory tests including lead toxicity screening for all Medicaid-eligible young clients
- Health education designed to assist the client in understanding expected developmental milestones, the benefits of disease prevention, healthy behaviors, and injury prevention.
- Vision, hearing, and dental screening in primary care, including a direct referral to a dentist for every client beginning at age 1 year

The following services are to be provided by trained professionals according to appropriate periodicity schedules:

- Dental services – at a minimum to include screening, preventive care, relief of pain and infections, restoration of teeth, and maintenance of dental health
- Vision services – at a minimum to include screening, diagnosis, and treatment for defects in vision, including eyeglasses
- Hearing services – at a minimum to include screening, diagnosis, and treatment for defects in hearing, including hearing aids and might include follow-up to newborn hearing screening for Medicaid enrolled clients

2. **Diagnosis**. When a screening examination indicates the need for further evaluation of a client's health, diagnostic services are provided. Follow-up contact is made to make sure that the recipient receives a complete diagnostic evaluation.

3. **Treatment**. Health care must be made available for treatment or other measures to correct or improve disabilities, physical and mental illnesses, or conditions discovered by the screening services.

4. **Other necessary health care**. The client is provided necessary health care, diagnostic services, treatment, and other measures to correct or improve defects, physical and mental illnesses, and conditions discovered by the screening services.

EPSDT *Care for Kids* in Iowa

Iowa's Early and Periodic Screening, Diagnosis and Treatment program is called EPSDT *Care for Kids*. The activities of the EPSDT *Care for Kids* program fall into four service categories: informing, care coordination, screening, and diagnosis and treatment. The following list summarizes the primary activities of each category:

Informing:

1. The client completes the Title XIX application at the local Department of Human Services (DHS) office and learns that an Agency will be in

contact about the EPSDT *Care for Kids* program benefits.

2. Iowa DHS provides the names of the newly eligible clients, along with demographic information, to the Iowa Department of Public Health (IDPH). IDPH makes the information available to the Title V contract Agency serving the area where the client lives.
3. Staff at the Title V Agency contacts the newly eligible client to explain the EPSDT *Care for Kids* program and benefits. The discussion covers the benefits of preventive health care services, location of services, support services available to help the client, and local resources.
4. The Title V Agency submits a claim to the Iowa Department of Public Health for informing the clients about the EPSDT *Care for Kids* program.

Care Coordination:

1. IDPH provides information to the Title V contract Agencies about clients that are due for EPSDT *Care for Kids* screenings.
2. A care coordinator at the Title V Agency contacts the client to determine whether assistance is needed to find a medical and dental home or to schedule an appointment for the screening. The care coordinator shall also assist the client with transportation, interpretation, developmental concerns, and other resources when needed.
3. If the client chooses to obtain screening services without assistance from the care coordinator, the client is given the care coordinator's name and telephone number for future reference.
4. The Title V Agency submits a claim to the Iowa Department of Public Health for care coordination for each client served.

Screening:

1. The appropriate health provider completes screenings according to the *Iowa Recommendations for Scheduling Care for Kids Screenings*.
2. The health provider submits a claim to Medicaid for each client screened.

Diagnosis and Treatment:

1. The primary health care provider offers diagnosis and treatment services or the client is referred to another health care provider.
2. If further diagnosis and treatment are indicated, the care coordinator offers assistance in locating appropriate resources, scheduling appointments, and assisting in arranging support services.
3. If no further diagnosis and treatment is indicated, the Agency and client are contacted again when the next periodic screen is due.
4. The care coordinator continues to follow-up with the needs of the client until all needs are addressed.

Title V Agency Responsibility for EPSDT *Care for Kids*

In Iowa, the Department of Human Services (DHS) is the administrative Agency for the EPSDT *Care for Kids* program. Through a formal written agreement, DHS engages the Iowa Department of Public Health (IDPH) to provide EPSDT *Care for Kids* informing and care coordination services for Iowa's Medicaid eligible clients. IDPH fulfills the responsibilities of this agreement by contracting with local Title V Child Health Agencies to work with clients in designated service areas.

Both IDPH and DHS agree that Title V Child Health Contract Agencies and their subcontractors have been very successful in working with clients covered by Medicaid. Clients are assisted in understanding Medicaid coverage and accessing services through the efforts of Title V Agencies. Title V Child Health Agencies receive reimbursement for EPSDT *Care for Kids* services.

Each IDPH Title V Child Health Contract Agency is required to have protocols to direct its activities related to the EPSDT *Care for Kids* program. Agency protocols are included in Chapter 8 of this handbook.

Client Rights under Medicaid

Clients enrolled in Medicaid are entitled to specific rights under the Medicaid program. Title V Agency staff should be familiar with these rights to be able to appropriately inform clients. Primary among these rights are the right to choose a provider and the right to appeal decisions made by Medicaid.

Choice of Provider

Federal rules mandate that each client has the freedom to choose its health care providers. To comply with these rules, Title V staff must be prepared to discuss EPSDT *Care for Kids* provider options with each client. Clients enrolled in Medicaid have the ability to choose a provider under their Medicaid status (fee-for-service, Meridian HMO, MediPASS, Iowa Wellness Plan, and Marketplace Choice Providers).

Clients must be informed of the financial consequences of choosing a non-Medicaid provider since Medicaid will not pay for services given by a non-Medicaid provider. A client's choice of a non-Medicaid provider should not be considered a refusal of services.

Right to Appeal

All Medicaid eligible clients have the right to appeal. Information on filing an appeal can be found on the DHS website at www.dhs.iowa.gov. Clients who have questions specific to the appeal process may contact their DHS worker or the Appeals Section at 515-281-3094. Although staff will be able to answer questions, they will not provide legal advice.

Common reasons for appeals include the following:

- Benefits are being terminated and the client believes the reason for the termination is incorrect

- Prior authorization is denied for a service
- Non-payment by Medicaid is sent to a creditor

Clients wishing to appeal may also wish to contact an attorney or Iowa Legal Aid at 1-800-532-1275. In Polk County, clients may call 515-243-1193.

Maintaining Confidentiality for the Client

An Agency contracting with IDPH to carry out the functions of the EPSDT *Care for Kids* program becomes an arm of the Medicaid Agency. All IDPH Title V Contract Agencies must meet the standards of confidentiality of a Medicaid Agency and follow Health Insurance Portability and Accountability Act (HIPAA) requirements.

IDPH Title V Contract Agencies can communicate with local DHS offices regarding client information without a release of information. Additional confidentiality guidelines are found in local contractor HIPAA policies and the IDPH HIPAA statement online at: http://www.idph.state.ia.us/hipaa_statement.asp.

Specific confidentiality guidelines related to the EPSDT *Care for Kids* program include those listed below.

- When an Agency sends correspondence to clients, the term "Medicaid" may not be used on the outside of envelopes, postcards, or in electronic transmissions that could be seen by those other than the intended recipient. Agencies may use the EPSDT *Care for Kids* logo and name on the outside of the envelope including the "Early and Periodic Screening, Diagnosis and Treatment" wording on the logo itself.
- When leaving messages on answering machines, the Agency name and "*Care for Kids*" may be left on the machine identifying the caller and the name of the client. For example, *"This is Sylvia from Care for Kids. I am calling to talk to the parent of [client's name] about his health insurance benefits. Sorry I missed you. Please call me at..."* If the answering machine does not give enough information to identify whose machine has been contacted, the message should be less specific, and the name of the client should not be mentioned.
- Postcards or notes with client information must be folded and sealed in such a way to protect individual health information. If notes are left at the door when the client is not home, the information must be sealed. Notes should not be left unless it can be determined that the address is correct and that the home is not vacant. There must be a notice on the outside of the note that says: *"This message may include confidential information. If this note is not for you, throw it away and call [Agency name and phone number]. Thank you."*

Documenting and Maintaining the Clinical and Fiscal Information

The IDPH web-based Child and Adolescent Reporting System (CAReS) is the official clinical record for all EPSDT *Care for Kids* informing and care coordination services. CAReS is used by IDPH Title V Child Health Contract Agencies to monitor client demographic information, needs, and services. All services provided by IDPH Title V Contract Agencies must be entered into the CAReS electronic record. Complete instructions for CAReS data entry are located in the CAReS User Manual at http://www.idph.state.ia.us/hpcdp/common/pdf/CARES_Manual.pdf.

Each IDPH Title V Contract Agency establishes policies related to the fiscal management of the EPSDT *Care for Kids* program. Each year, Contract Agencies complete a Cost Analysis to establish their local Agency cost for providing each service. Agency staff members keep a continuous time study that is used to help determine the Agency's costs for providing the EPSDT *Care for Kids* services.

Length of Time for Maintaining Records

The contract between IDPH and the local Child Health Agency addresses the retention of both medical records and fiscal/other program documents. The following language is a part of the General Conditions of the contract:

- **Medical records**: "The contractor shall retain all medical records for a period of six years from the day the contractor submits its final expenditure report; or in the case of a minor patient or client, for a period of one year after the patient or client attains the age of majority; whichever is later."
- **Fiscal and other program records**: "The contractor shall retain all accounting and financial records, programmatic records, supporting documents, statistical records and other records reasonably considered as pertinent to the contract for a period of five (5) years from the day the CONTRACTOR submits its final expenditure report. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the five (5) year period, the records must be retained until completion of the action and resolution of all issues which arise from it or until the end of the regular five (5) year period; whichever is later. Client records which are non-medical must be retained for a period of five (5) years."

Medicaid may audit records for a period of five years after a claim is submitted or if an audit is in process, five years after the completion of the audit. Agencies must keep all files for five years after the completion of the audit, even if the original retention expiration is before that date.

Signature Log

Contractors are also required to maintain a signature log of all staff providing Child Health services that include their first name, last name, credentials, full signature, initials, and CAReS user names. This log is

important for reference in the event of an audit, as it is the link to required signatures for staff providing services that are entered into CAReS.

Claims Review

With proper identification, authorized representatives of the Iowa Department of Public Health (IDPH), Department of Human Services (DHS), Centers for Medicare and Medicaid Services (CMS), and/or the Office of Inspector General (OIG) have the right to review the clinical and fiscal records of an IDPH Title V contract Agency to determine whether:

- The claims have accurately been paid for services delivered.
- The IDPH Title V contract Agency has furnished the services to Medicaid recipients.
- The IDPH Title V contract Agency has retained clinical and fiscal records which substantiate claims submitted for payment during the audit period.

Using the Informing and Care Coordination Handbook in Working with Clients

As discussed previously, the purpose of this handbook is to guide Title V Agencies in the provision of two important components of Iowa's EPSDT *Care for Kids* program: informing and care coordination. The remaining chapters of the handbook are written for front-line staff working directly with clients.

Chapter 2 provides staff with step-by-step directions for informing clients about the EPSDT *Care for Kids* program. On occasion staff members are unable to locate clients to complete the informing process.

Chapter 3 assists staff to provide care coordination for the clients that need help to obtain health care services.

Chapter 4 focuses on important community linkages for clients.

Chapter 5 explains how Agency protocols guide staff members in providing EPSDT *Care for Kids* services to clients.

Chapter 6 briefly explains how the Agency manages the finances of the EPSDT *Care for Kids* services.

Chapter 7 contains additional resources referred to in the first seven chapters of this handbook.

Front-line staff must have access to the Agency-specific EPSDT *Care for Kids* protocols used to carry out the guidelines in this handbook. It is also important to keep a file of updates related to the Medicaid program. For convenience, a Chapter 8 tab is for Agency protocols and a Chapter 9 tab is for IME Information Releases.

Chapter 2 Informing

Why Clients Need Informing

Newly eligible clients ages 0 to 21 years, don't always know about all the services available through their Medicaid coverage. Through a process called "Informing" clients are told about the health care services covered under the EPSDT *Care for Kids* program.

Clients ages 19-20 may be enrolled in the Iowa Health and Wellness Plan (IHAWP), either on the Iowa Wellness Plan or the Marketplace Choice Plan. These clients receive the same EPSDT services as clients enrolled in other Medicaid programs, and also need to know about their benefits.

This chapter provides step-by-step instructions for informing.

What to Inform the Client About

Inform the client of the services available under the EPSDT *Care for Kids* program, including care coordination, health screening services, and dental care. At the same time, help the client understand the importance of preventive medical and oral health care for all clients in the family. The informing discussion will include the topics listed below:

- Promote the benefits of preventive medical and oral health care
- Explain the services available under EPSDT *Care for Kids* including care coordination services and screening services
- Explain components of the EPSDT screen according to *The Iowa Recommendations for Scheduling Care for Kids Screenings,* and ACIP Immunization Schedule
- Explain that they may choose their health care providers under Medicaid
- Provide information about the process of selecting a health care provider
- Encourage the client to establish a medical home and dental home
- Inform the client where screening services are available and how to obtain them
- Provide information on the support services available under EPSDT, such as transportation and interpretation services
- Provide information about other resources in the community

How the Client Qualifies for Informing

When a client meets Medicaid eligibility requirements and becomes newly enrolled in the Medicaid program, the client qualifies for informing services. The client must be enrolled in the Medicaid program on the date the informing service is provided.

Information about the client newly eligible for Medicaid will appear on the Informing List in CAReS. The report will provide the client's name and contact information to begin the informing process.

If Medicaid eligibility status of a client needs to be checked, contact the

Iowa Medicaid Enterprise (IME) Eligibility Verification System (ELVS) at 800-338-7752 (or 515-323-9639 in Des Moines). Client eligibility can also be verified using the IME Web Portal Access at: http://dhs.iowa.gov/ime/providers/tools-trainings-and-services/provider-tools

Contract Agency Responsibility for Informing

IDPH contracts with community-based Agencies to provide services to clients in a service area. Agencies are responsible for informing clients under age 21 who are newly eligible for Medicaid fee-for-service, Meridan HMO, MediPASS, or IHAWP coverage. Each month, clients on the Agency's Informing List must be informed within 30 days of the beginning of the month.

The EPSDT Coordinator is responsible for developing informing protocols and making sure that the Agency's practices are consistent with the required components of the informing process.

The Agency may choose to inform the families of foster care children or those in Medicaid's Medically Needy with Spend-down Program. However, the county DHS offices have primary responsibility for informing these clients.

Skills Needed for Informing

Each Title V Child Health contract Agency is required to designate one or more employees to carry out informing services.

In order to be effective in informing clients about the EPSDT *Care for Kids* program, certain skills are necessary. Care coordinators need to:

- Be trained in the EPSDT *Care for Kids* program and care coordination utilizing IDPH training.
- Communicate clearly when writing and speaking to clients
- Relate to clients to encourage involvement in the process
- Assess client needs and refer to appropriate providers
- Establish and maintain linkages with local providers and community resources
- Tailor informing services to address client choices, preferences, and special needs such as language barriers, low literacy levels, and hearing or sight impairment
- Understand the EPSDT *Care for Kids* program, including components of *The Iowa Recommendations for Scheduling Care for Kids Screenings*
- Understand the Immunization Schedule from the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP)
- Understand and explain child and adolescent growth and development

The Three Steps of Informing

Informing is a process. There may be three steps to the informing process:

1. The Initial Inform
2. The Inform Follow-up(s)
3. The Inform Completion

The next sections of this chapter outline each step of the informing process.

The Initial Inform

The first contact made with a client who is newly eligible for Medicaid is called the "Initial Inform." Agencies must have their own protocols to guide the steps in providing the initial inform.

As a first step, an Agency may choose to send a letter of introduction to the client. The letter will briefly describe the EPSDT *Care for Kids* program. The letter may provide information about services in the area and introduce the Agency's care coordinator. A sample initial informing letter is included in this handbook in Appendix 2.

The initial inform letter may ask the client to respond by mail or phone. Some Agencies tell clients that the Agency will follow-up with a phone call or visit. The EPSDT *Care for Kids* brochure should be included with the initial inform letter. The Agency may also include other community resources with the mailing. Agencies can obtain EPSDT *Care for Kids* brochures at no cost by calling Prison Industries at 1-800-432-9163.

Which Clients Need the Initial Inform

The list of Medicaid newly eligible clients is obtained from the Informing List in the CAReS. This report identifies all newly Medicaid eligible clients under age 21 in the Agency's geographic service area by county.

Some of the clients on the Informing List have never been eligible for Medicaid. Some may have received Medicaid benefits in the past. Any client who becomes eligible again, after being off Medicaid for the previous 90 days or more, is considered to be newly eligible and should receive informing services.

Timeline for the Initial Inform

The Agency is required to provide informing services each month. The process begins when the CAReS Informing List is printed at the beginning of the month, as close to the first business day as possible. Then the initial inform is provided to the newly eligible clients as soon as possible, after the report is printed. The Agency is required to notify newly eligible clients within 30 days of printing the monthly report in order to meet federal requirements.

Mailing Labels for the Initial Inform

CAReS will generate mailing labels that should be used in mailing initial informing letters. CAReS will create labels grouped by family, since only one mailing per family is sent. Print the labels on the same day the CAReS report of newly eligible clients is generated.

Documenting the Initial Inform

Although this handbook contains pointers on documenting the steps of the informing process, the *CAReS User Manual* provides specific guidelines for entering information into CAReS.

Staff must document the initial inform in CAReS for each Medicaid eligible client in the family on the Informing List, by selecting "Initial inform" under the "Informing and Care Coordination" service category. Be sure to enter initial informs **by the end of the month that the Informing List was run**. Timely documentation is required to assure that clients will not appear again on Informing Lists in subsequent months.

In service notes, it is important to thoroughly describe the service provided. Required elements for documentation of the Initial Informing are:

1. Place of service (if not agency main address)
2. Month and year the client appeared on the Informing List
3. Statement that an informing letter or packet was sent
4. First and last name of the service provider and their credentials if not entering their own data. If entering own data, the CAReS username may be used as long as a signature log is maintained.
5. Either follow-ups or completions are required in the month of the intial inform.

If clerical staff assist in data entry of the initial inform, they enter the first name, last name, and credentials of the individual providing the initial inform service. CAReS automatically records the name of the individual entering the data when service notes are entered.

Documenting the Inform Follow-up

Staff must document each inform follow-up attempt in CAReS for each client in the family on the Informing List. Select "Inform Follow-up" under the "Informing and Care Coordination Services" category.

Record service notes to thoroughly describe the service provided, following the instructions for documentation of services. Include:

1. Place of service (if not agency main address)
2. The time of day the attempt to contact the family was made. Report an actual time with a.m. and p.m. (e.g. 12:15 p.m.) This may be entered into the Time in/Time out field(s) if desired.
3. Description of the attempt to reach the family and the result of this attempt (no answer, busy signal, phone disconnected, etc.) including any message left and the content of that message.
4. If a follow-up letter is noted when client phone numbers are available, this occurs **only after documentation of failed phone attempts.**
5. First and last name of the service provider and their credentials if not entering their own data. If entering own data, the CAReS username may be used as long as a signature log is maintained.

If clerical staff assist in data entry of the inform follow-up, they enter the first name, last name, and credentials of the individual providing the inform follow-up. CAReS automatically records the name of the individual entering the data when service notes are entered.

The Inform Completion

The goal of the informing process is to successfully contact the client by phone or face-to-face to explain the EPSDT services for which the client is now eligible. This is referred to as "Inform Completion". Inform completion is only achieved when the description of services available under the EPSDT *Care for Kids* program is given directly to the client in person or on the telephone.

Leaving a message on an answering machine or voice mail might be part of an inform follow-up strategy, but it is not an inform completion. Receiving a response to a form letter also does not constitute inform completion.

When serving clients newly eligible for Medicaid, it is expected that informing services are completed prior to providing (and billing) care coordination services. Any verbal or face-to-face contact with the client within 12 months of the initial inform, provides opportunity to complete the informing process.

The Inform Completion Conversation

There are many possible topics for the inform completion discussion, depending on the knowledge level and needs of the clients. These topics include:

- The benefits of preventive medical and oral health care
- The services available under EPSDT *Care for Kids* including care coordination services and screening services
- The components of the EPSDT screen according to *The Iowa Recommendations for Scheduling Care for Kids Screenings* and ACIP Immunization Schedule
- Freedom of choice of their health care providers under Medicaid
- Information about the process of selecting a health care provider
- The importance of the client establishing a medical home and dental home
- Information on where screening services are available and how to obtain them
- Information on the support services available under EPSDT, such as transportation and interpretation services
- Information about other resources in the community

At inform completion, emphasize that care coordination services are available through the EPSDT *Care for Kids* program to link the client with the health care system. For this discussion, be familiar with the guidelines for care coordination in Chapter 4 of this handbook.

After describing care coordination services, ask whether the client needs the assistance of a care coordinator. The client will make one of the choices listed below.

- *The client can obtain services without the assistance of a care coordinator.* A client may choose to access health services without help from the Title V contract Agency. If so, provide the client with Agency contact information, including the name of the care coordinator, in case the needs of the client change over time.
- *The client needs the assistance of a care coordinator to obtain health care services.* In this case, assist the client in obtaining medical screenings and dental exams, and other recommended diagnostic, treatment, and support services. (Note that any coordination of care as a part of the inform completion is considered part of the informing process. Do not bill care coordination for this activity.)
- *The client refuses care coordination.* Occasionally, a client might refuse care coordination services recommended based on the care coordinator's assessment of client needs. In those instances, provide the client with Agency contact information, including the name of the care coordinator, in case the needs of the client change.

Documenting the Inform Completion

Document the inform completion in CAReS for each Medicaid eligible client in the family on the Informing List. Select "Inform Completion" under the "Informing and Care Coordination Services" category.

Record service notes to thoroughly describe the service provided. When documenting the inform completion, include:

1. Place of service (if not agency main address)
2. With whom staff member spoke
3. Explanation of full benefits and services available under the EPSDT Care for Kids program
4. Report status of medical and dental well child visits including:
    a. Assessment of immunization status,
    b. Timeframe of past or upcoming medical and dental appointments, and
    c. Identification of medical and dental providers
5. Information provided on other needed resources available in the community as requested by client/family
6. Other issues addressed
7. Information/feedback from client/family (documentation of understanding, etc.)
8. Outcomes including referrals made and plans for follow up, as needed
9. First and last name of the service provider and their credentials if not entering their own data. If entering own data, the CAReS username may be used as long as a signature log is maintained.

If clerical staff assist in data entry of the inform follow-up, they enter the first name, last name, and credentials of the individual providing the inform completion. CAReS automatically records the name of the individual entering the data when service notes are entered.

If the client refuses care coordination and does not wish to be contacted again, an Agency may choose to discharge the client in CAReS as "Requested Discharge." This removes the client's name from later CAReS reports.

Billing for Informing Services

Once the initial inform letter to the client is sent, an Agency may submit a claim to the Iowa Department of Public Health for the informing process. The claim covers the entire informing service that staff provide to the client, including the initial inform, inform follow-ups, and inform completion. A claim is submitted for informing all clients in the family on the Informing List, not one claim per client.

The claim for informing also covers any assistance provided during the inform completion discussion with the client. Do not bill or document a care coordination service for any portion of the inform completion contact.

Chapter 3 Care Coordination

Why Clients Need Care Coordination

Once clients have been informed about the EPSDT *Care for Kids* program, they will decide whether they need further assistance. Some clients may choose to obtain services without any help. Other clients may request assistance in obtaining medical and dental screenings and other services. Through care coordination an Agency can assist those clients.

Care coordination is the process of linking the client to the health care system. Care coordination is a Child Health service provided to all clients regardless of Medicaid eligibility.

This chapter provides step-by-step instructions for care coordination.

How Care Coordination Supports Clients

The EPSDT *Care for Kids* program places a high priority on helping clients make decisions based on needs and preferences. The program encourages clients to have medical and dental homes for continuity of care. The program assures that overall health is improved through periodic exams, early diagnosis, and appropriate treatment.

Provide care coordination to help clients:

- Become independent health consumers
- Develop healthy beliefs, attitudes, and behaviors
- Make informed health care choices
- Establish and maintain medical homes and dental homes
- Improve their health and physical well-being

Care Coordination Services

Care coordinators work directly with the client through a variety of strategies, including talking with the client on the phone or in person. An Agency must have its own protocols to guide the steps in providing care coordination. Through these activities, the client will be linked to the health care system and encouraged to participate in preventive medical and oral health care.

Specific care coordination activities will depend on the needs and preferences of the client. The following list contains some of the possible activities:

- Reminding clients that periodic well-child screenings and dental exams are due
- Assisting with scheduling appointments (outside of the Agency)
- Assisting the client to prepare a list of questions or concerns prior to the medical or dental visit
- Following up to make sure the client received the care intended at the appointment
- Following up to reschedule missed appointments

- Assisting clients when referral for further care is needed
- Arranging support services such as transportation to Medicaid providers or interpreter services
- Monitoring medical and dental care plans
- Linking clients to health-related community services
- Providing support as clients become independent health care consumers

Although an Agency may provide assistance to clients by mailing them a letter or other print materials, typically a mailing does not constitute a billable care coordination service. An exception has been made for the 1st Five program where detailed, client-specific care coordination letters sent to health care providers may be billable.

Billable care coordination services must include phone, text, email, or face-to-face dialogue with clients to assist them with Medicaid related services such as medical, dental, mental health, transportation, interpretation, Child Health Specialty Clinics, AEA, or substance abuse programs. As long as Medicaid related services/programs are addressed, linkage to non-Medicaid resources (such as child care, WIC, parenting programs, social services, legal services, food, clothing, housing, and shelter services) may also be included in the billable time spent with the client.

Skills Needed for Care Coordination

Each Title V Child Health contract Agency is required to designate one or more employees to carry out care coordination. In order to be effective in care coordination related to the EPSDT *Care for Kids* program, certain skills are necessary. Care coordinators need to:

- Be trained on the EPSDT *Care for Kids* program and care coordination services utilizing IDPH training.
- Communicate clearly in writing with clients
- Communicate clearly in speaking to clients in person and on the telephone
- Relate to clients to encourage involvement in the process
- Assess client needs and refer to appropriate providers
- Establish and maintain linkages with local providers and community resources
- Tailor care coordination services to meet special needs of the client, such as language barriers, low literacy levels, and hearing or sight impairment
- Understand the impact of the client's culturally-related health beliefs
- Understand the EPSDT *Care for Kids* program including components of *The Iowa Recommendations for Scheduling Care for Kids*

Screenings

- Understand the Immunization Schedule from the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP)
- Understand and explain child and adolescent growth and development to clients.
- Understand how to use a client-centered, strength-based approach

A sample job description for a care coordinator is located in Appendix 4 of this handbook.

Care Coordination for Children with Special Health Care Needs

Child Health Specialty Clinics (CHSC) is Iowa's Title V program for clients with special health care needs. The CHSC mission is to improve the health, development, and well-being of children and youth with special health care needs in partnership with families, service providers, communities, and policy makers.

The CHSC public health vision is that all of Iowa's children with special needs will have access to quality community-based services. The CHSC statewide program includes 14 regional centers that provide services to children with special health care needs and an administrative center at the University of Iowa.

Regional CHSC staff are skilled in coordinating care so that local resources are used in the most effective and convenient manner possible. The CHSC parent consultants assure that services are client-centered, clients consider options, and make informed decisions about their care.

Care Coordination: Reminding Clients when due for a Screening

As mentioned previously, it is important to be familiar with *The Iowa Recommendations for Scheduling Care for Kids Screenings.* A key component of the work as a care coordinator is to discuss the importance of screenings with the client and encourage them to make appointments with their providers based on the recommended schedule. Additionally, follow-up with the clients to make sure that they received the recommended services and to assist in scheduling additional needed services may be needed.

CAReS produces two reports to help identify client that are due for screenings.

- Care Coordination List-In Agency: This report lists all the clients in an Agency home that are due for screenings. The "Agency home" designation means that the Agency has taken responsibility for these clients. As the care coordinator, print this report and remind the clients that the screenings are due.
- Care Coordination List-No Agency: This report lists, by county of residence, clients who are due for screenings but have not been in an Agency home. This report can be used as an outreach tool to help contact clients that have been difficult to locate in the past.

As a care coordinator, there are a variety of ways to remind a client they are due for a screening according to *The Iowa Recommendations for Scheduling Care for Kids Screenings,* including mailing the client a written reminder, speaking to the client on the telephone, or in person in a clinic setting. Agency's care coordination protocols should provide guidance for which strategy to use. Remember that mailing written reminders of periodic screens does not constitute a billable care coordination service.

Care Coordination: Assisting the Client to Overcome a Communication Barrier

Sometimes a client has difficulty getting health care for a client because of a communication problem such as a language barrier, hearing impairment, or health literacy obstacle. Care coordinators help the client overcome the barrier.

There are a variety of strategies to assist a client with a communication problem. The Agency's care coordination protocols will guide using a particular strategy, such as speaking with the client on the phone or at the Agency in the preferred language or communication method. In many instances, care coordinators help the client by arranging for interpreter services.

As a care coordinator, determine whether Agency materials are at an appropriate reading level and culturally appropriate for the clients in the Agency service area. Care coordinator's insights will be important to guide the Agency in making appropriate changes to protocols and materials.

Care Coordination: Assisting the Client to Overcome a Transportation Barrier

Title V Contract Agencies assist clients to arrange transportation to Medicaid health providers (medical, dental, and mental health).

Title V Contract Agencies both arrange and bill Medicaid for **in-town (local)** transportation services. Clients seeking medical care ***outside*** of their community should obtain assistance by contacting Transportation Management Services (TMS), the Medicaid broker for transportation services. Contact TMS at 1-866-572-7662.

Care Coordination: Making a Home Visit for a High Blood Lead or Medically Necessary Condition

Most care coordination activities will involve talking to clients on the telephone or at the Agency office or clinic setting. However, an Agency must be prepared to provide home visits to clients when indicated.

Two instances when care coordination might be provided during a home visit to the client are outlined below.

1. Each client with a blood lead level equal to or above 15 micrograms per deciliter must receive a skilled nursing visit. An RN care coordinator may follow up on this high blood lead level by making a home visit to:
    - Assess the client's knowledge of lead poisoning and instruct the client regarding nutrition, housekeeping, and other relevant issues
    - Assist the client in making and keeping follow-up appointments

- Remind the family to notify the client's lead program case manager if the family moves
- Remind the family to inform the client's current and future health care providers of the elevated lead level and any subsequent tests that may demonstrate a lower blood lead level

2. A home visit might also be indicated when there is a client that requires medically necessary care coordination for a health related condition. Such necessity may include clients that lack phone service or are otherwise hard-to-reach. The purpose of this home visit might be to:

   - Provide information about available medical and dental care services
   - Coordinate access to care
   - Assist the client in making health care appointments (other than those at the Agency)
   - Make referrals
   - Coordinate access to needed support services
   - Follow-up to assure that services were received

Documenting Care Coordination Services

Document care coordination services in CAReS. In most instances check "Care Coordination" under the "Informing and Care Coordination Services" category. An exception is when care coordination for an oral health need is provided. Then check "Care Coordination" under the "Dental Services" category. Mark "Home visit" as the interaction type for home visits for care coordination services.

Record service notes in CAReS to thoroughly describe the service provided. Required elements for documentation of care coordination:

1. Place of service (if not agency main address)
2. With whom staff member spoke
3. The issues addressed and Medicaid related concerns that the client/family shared
4. Staff responses to client/family concerns and issues
5. If coordinating regular medical or dental care servcies, report the following:
   a. Assessment of immunization status
   b. Timeframe of past or upcoming medical and dental appointments, and
   c. Identification of medical and dental providers
6. Specific information on referrals
7. Details on outcomes and plan for follow up as needed
8. Information/feedback from client/family (documentation of

understanding, etc.)

9. First and last name of person performing the service & credentials if not entering own data. If entering own data, the CAReS username may be used as long as a signature log is maintained.

For **care coordination of transportation services**, include the following required documentation elements:

1. Place of service (if not agency main address)
2. With whom staff member spoke
3. Type of Medicaid covered service for transportation (medical, pharmacy, dental, mental health)
4. Date of planned trip
5. Type of ride to be provided (cab, bus, volunteer, TMS)
6. First and last name of person performing the service & credentials if not entering own data. If entering own data, the CAReS/WHIS username may be used as long as a signature log is maintained.

For targeted follow up care coordination notes, the date of last wellness exam, name of provider, and assessment of immunization status is not required. Indicate in the note if it is a follow-up care coordination service. Address any additional family needs.

If clerical staff assist in data entry of the care coordination service, they enter the first name, last name, and credentials of the individual providing the care coordination service. CAReS automatically records the name of the individual entering the data when service notes are entered.

If care coordination is provided for multiple clients in the family, document the care coordination in the CAReS record for each client served.

Note: If screening reminders are sent to clients to remind them of periodic screens that are due, mark "Screening Reminder" in CAReS. The mailing of screening reminders does not constitute a billable care coordination service.

Billing Care Coordination Services

By contract, the Agency is required to serve all clients who need care coordination whether enrolled in Medicaid or not. The Agency will submit a claim to the Iowa Department of Public Health for care coordination services for Medicaid clients. Select the appropriate primary payment source among the following options for billing care coordination to IDPH:

- Title XIX – FFS
- Title XIX – PE & CC
  Title XIX – MediPASS/HMO
- IHAWP for 19 & 20 year olds
- 1st Five should be selected as the secondary payment source for all 1st Five care coordination.

The claim is based upon the actual time spent providing care coordination. If the documentation in CAReS is completed **by the service provider on the same date as the care coordination service,** time spent documenting the service provision may also be included. If care coordination is provided to more than one client during a contact with the family, separate out the time spent providing care coordination for each client.

Home visits for care coordination are also billed to the Iowa Department of Public Health for Medicaid clients.

Care coordination for Title V clients is not billed fee for service to IDPH. Instead, these costs are covered through Title V grant funds.

Note that the following activities are NOT billable care coordination services:

- Sending written reminders that periodic screens are due
- Unsuccessful attempts to reach a client for care coordination services
- Activities that are a part of the maternal health postpartum visit. Any care coordination for the new baby is part of this postpartum visit billed under the maternal health program.
- Making appointments for services provided within Agency
- Reporting lab results to the client or medical home for lab tests that are conducted within Agency
- Care coordination provided on the same day as a direct care service provided within Agency. Referral or making appointments on the same date as direct care is considered part of the direct care service.

Typically, care coordination is not payable on the same date as a direct care service. However, the following exceptions to this policy apply:

- Care coordination to arrange transportation services may occur on the same day as a direct care service.
- Interpretation for a care coordination service may be billed on the same day as the care coordination service.
- Medical care coordination may be billed if a dental direct care service is provided by other staff (e.g.RDH) on the same day (as long as no medical direct care was provided on that date).
- Dental care coordination may be billed if a medical direct care service is provided by other staff (e.g. Nurse) on the same day (as long as no dental direct care was provided on that date).

Chapter 4 Community Linkages

Assisting Clients through Community Linkages

Development of community linkages is an important component of the role of care coordinators. This responsibility includes efforts to identify community level resources, link clients with services, identify gaps and barriers in service, and promote development of community capacity.

This chapter provides guidelines to help care coordinators establish community linkages.

Important Community Linkages

It is not necessary to know every resource in the community or all the specifics about each resource. But a working knowledge of resources and where to find additional information in order to assist clients is needed.

The Iowa Department of Public Health has a contract with Iowa State University Extension to provide information and referral for clients receiving EPSDT *Care for Kids* services via the Healthy Families Line at 1-800-369-2229. The Healthy Families Line provides resource information on Maternal Health, Child Health, and Family Planning services.

Many regions, counties or towns have regular meetings for social service and health care providers. These meetings promote networking and information sharing to ensure that local services and resources are not duplicated. Attendance at these meetings can be very beneficial to the Agency and the clients served.

Strong relationships with community partners help facilitate linkages for clients. The development of formal and informal connections among Agencies and organizations is essential to coordinate the planning and delivery of effective services.

Subcontracts

It is important for Agencies to establish written subcontracts and agreements with local entities to establish expectations of both parties. Agreements may include information and responsibilities regarding:

(1) A list of the work and services to be performed by the subcontractor.

(2) The contract policies and requirements.

(3) Provision for the Department, the Contractor, and any of their duly authorized representatives to have access, for the purpose of audit and examination, to any documents, papers, and records of the subcontractor pertinent to the subcontract.

(4) The amount of the subcontract.

(5) A line item budget of specific costs to be reimbursed under the subcontract or agreement or other cost basis for determining the amount of the subcontract as appropriate.

(6) A statement that all provisions of this contract are included in the

subcontract including audit requirements.

(7) Period of performance.

(8) Any additional subcontract conditions.

Establishing Relationships

There are many ways to establish relationships with community partners. Linkages are established and maintained through:

- Verbal communication
- Personal contact
- Letters of introduction
- Newsletters
- Peer networks
- Involvement in community task forces, advisory committees, and boards
- Training programs
- Awareness campaigns
- Agency tours
- Systematic follow-up

Primary and Specialty Health Care Providers

Facilitating medical homes for clients is an important function of the Child Health program. The following are important linkages that can serve as medical homes and sources for further diagnosis and treatment.

- Primary care practitioners (doctor's offices and other practitioners such as nurse practitioners)
- Community Health Centers offer free and low-cost (sliding fee scale) health care clinics.
- Child Health Specialty Clinics (CHSC) serve Iowa children and youth from birth through age 21 years with, or at risk of, a chronic health condition or disability that includes psychosocial, physical, health-related educational or behavioral needs. The CHSC statewide program includes 14 regional centers that provide services to children with special health care needs and an administrative center at the University of Iowa.

Dental Care Providers

Dental services are required components of the EPSDT Care for Kids program. The American Association of Pediatric Dentistry (AAPD) recommends that infants see a dentist by 12 months of age. Access to dental providers can be very difficult in many areas of the state due to a shortage of providers and a lack of providers willing to see young children and/or Medicaid clients.

Establishing linkages is essential and can best be accomplished through regular, personal contact to provide information about Agency services and to share mutual concerns. Work with the Agency's I-Smile Coordinator to identify dentists for clients.

Clients with special health care needs often experience additional access barriers to dental services. To link with a dentist who is willing to treat low-income clients age 0-21 who are disabled, contact the Center for Disabilities and Development at the University of Iowa (319-356-1513).

Educational Services

The following Agencies provide educational services and support for clients:

- Early ACCESS (IDEA, Part C – Early Intervention) - a collaboration of public health, human services, Child Health Specialty Clinics and education services that link clients birth to age 3 who have developmental delays or a high probability of delay to needed services
- Early Head Start – a comprehensive child development program for client birth to age three
- Head Start – a comprehensive child development program including classroom and home-based preschool for client 3 to age 5 years of age
- Area Education Agency (AEA) – educational support including speech therapy, occupational therapy, and physical therapy for clients birth to age 22
- Local Education Agency (LEA) – local school districts that provide educational services for clients age 3 to 21
- Preschools – educational services for clients under age 6

Human Service Providers and Other Resources

There are many human service providers and other Agencies available to help meet the needs of clients. This partial listing provides brief descriptions of some of the most important community resources available.

- Child Care Resource and Referral (CCRR) – provide information and referrals to appropriate short-term, drop-in or long-term child care services. Iowa has a system of five Agencies, each district covering multiple counties.

- Parenting programs – parent education, counseling and/or support services for at risk clients
- Local Department of Human Services Income Maintenance Workers- http://dhs.iowa.gov/dhs_office_locator
- Local Department of Human Services Child Abuse Unit – investigation and intervention with clients who are victims of physical, emotional, or sexual abuse
- Teen pregnancy prevention and support services – abstinence education and/or education and counseling services to prevent pregnancies or support teen moms and dads
- Family planning programs - pre-conception counseling and birth control
- Substance abuse prevention and treatment services – prevention or treatment services for alcohol or drug dependency
- Interpreter and translation services – assistance with communication during appointments, including those who are hearing impaired
- Legal aid – Legal services for families that meet income guidelines
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – food and nutrition counseling services for pregnant women, infants and children under age 5, who meet income guidelines
- Food Assistance program – for purchase of food for families who meet income guidelines
- Family Investment Program (FIP) – financial and family support for families who meet income guidelines
- Supplemental Security Income (SSI) – financial support for children who have a disability and meet income guidelines
- Housing programs – low income housing and energy assistance
- Shelters for the homeless population or women with children who are victims of physical, emotional, or sexual abuse
- Transportation programs for accessing medical, dental, and/or mental health services provided by
    - Title V Agencies for in town transportation,
    - TMS for out of town transportation at 1-866-572-7662.
- Lead poisoning prevention programs – access to blood lead testing, provide case management services, and provide education regarding childhood lead poisoning

Chapter 5 Protocols

What are Agency Protocols

Protocols clarify Agency policy and provide explanation to staff about how services will be delivered. Protocols help the Agency provide the best service possible by:

- Assuring continuity and quality of care
- Standardizing activities among different staff members
- Standardizing activities among subcontract Agencies
- Assisting in new staff orientation
- Assuring quality of services
- Providing direction for uniform clinical documentation

Protocols are maintained on file within the Agency and a copy is given to each subcontract Agency. Subcontract Agencies follow the contract Agency protocols to maintain consistency and continuity.

Chapter 6 provides general guidelines about Agency protocols. Chapter 9 tab has been provided in this handbook for the placement of Agency protocols.

Writing Protocols

When writing Agency protocols, IDPH Title V contract and subcontract Agencies identify how the staff carries out EPSDT *Care for Kids* activities according to contract requirements and statewide program guidelines. Protocols reflect the unique needs, practices and systems of the local service area.

Agency protocols serve as expansions of the guidelines provided in this handbook. When writing local protocols it is not necessary to repeat the information in this handbook, although key components of the handbook may be referenced.

Once protocols are written, the approval and responsibility for implementation of the Agency's protocols lies with the Agency administrator. Protocols must be revised and updated annually.

Information to include in protocols

The format for writing protocols should include why, what, who, where, when, and how services are provided. Protocols should contain information such as:

- Purpose statement including why the service is important and the expected outcome for clients
- Description of the service or procedure
- Names or job descriptions for persons authorized and trained to perform the activity
- Location of the service delivery
- Timeline for accomplishing the activity
- Procedures for assuring follow-up activities
- Procedures for documenting services or procedures
- Billing procedures
- Administrative activities
- Bookkeeping
- A signature line for the sub-contract Agency
- An annual review/revision date
- Date written and the review dates
- Signature line for Agency management
- Reference to other policies and the source of authority such as EPSDT *Care for Kids* Handbook, MCH contract, and MCH Administrative Manual

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Informing Protocols

At a minimum, the Agency's informing protocols must include:

- What staff member will be assigned to specific components of the service?
- What methods of direct contact will be used (phone calls, home visits, clinic visits)?
- How many attempts will be made to contact a client?
- What information is needed to complete the informing process?
- What is the informing message by age?
- What are the key points to be covered in each call?
- When does documentation take place?
- What should be included when documenting the service?
- What is done if the Agency is unable to contact the client (follow-up letters, phone calls, home visit)?
- What are the Agency-specific criteria for discharge?
- What are the provisions for assuring confidentiality?
- What are the procedures for documentation consistent with program guidelines?
- What are the provisions to assure that documentation supports the services billed?

It is recommended that a sample message for contacts or calls be included in the protocol that lists the purpose of the call, points to be covered, "red flag" words to avoid, and statements that have been found to improve communication with clients.

Care Coordination Protocols

At a minimum, the Agency's care coordination protocols must include:

- Who will provide the service?
- What methods of contact are utilized (letters, phone calls, home visits)?
- How many attempts should be made to contact the client?
- What is the care coordination message by age (key points to be covered in each call)?
- When does documentation take place?
- What should be included when documenting the service provided?
- What is done if the Agency is unable to contact the client?
- What time of day will services be available?
- When are home visits indicated?
- What are the provisions for making home visits?
- What are the safety issues for staff making home visits?

Care coordination protocols must also include:

- Referral sources and procedures (including Child Health Specialty Clinics)
- Methods for contacting a hard-to-reach client
- Confidentiality guidelines, Agency HIPAA contact
- Provisions to assure that documentation supports the services billed
- Procedures for documenting care coordination refusal services
- Transition of clients who move out of the service area
- Agency-specific criteria for discharge

Referral protocols must also be included to address:

- Who will provide the service?
- How will the Agency address client's needs?
- How will the Agency match client's needs with available services?
- How will the client be connected to the service?
- How will follow-up after the service be scheduled?
- What are the available community-based referral systems?
- What methods of contact will be used (with client, provider, and other Agencies)?
- What should be included when documenting the referral service?

It is recommended that a sample care coordination message be included that lists the purpose of the contact, points to cover (such as services to expect at the next well-child visit and importance of preventive care), "red flag" words to avoid, open-ended questions for families, and statements that have been found to improve the communication with clients.

Chapter 6 Financial Management

Importance of Financial Management

Providing quality informing and care coordination services to clients requires adequate funds to carry out all program activities. Although Medicaid is the primary payer for these services (through an agreement with the Iowa Department of Public Health (IDPH)), each Agency is expected to explore additional sources of funding. Ultimately, the various funding sources result in a braided financial structure that allows the Agency to serve the needs of all clients.

Chapter 7 provides basic information about the financial management of the EPSDT *Care for Kids* program. These guidelines will help care coordinators work closely with Agency administrative and fiscal staff.

Determining Cost

Each program staff member plays a role in the financial management of the EPSDT *Care for Kids* program. For front-line staff providing informing and care coordination services this role starts with an understanding of the costs of providing the services.

Each year, an Agency prepares a Maternal and Child Health (MCH) Cost Analysis. The cost analysis takes into account all costs required to provide a service in the entire area, including those of subcontractors. The cost of a service includes staff time, staff training, travel, supplies, telephone, fax, computers, printers, equipment, and other costs to run the everyday operations of the organization. Agencies **bill their cost** to provide services as determined by their cost analysis.

Medicaid reimbursement rates are set by the Iowa legislature and approved by the Center for Medicare and Medicaid Services (CMS). Title V Child Health Agencies bill the cost of services determined by the MCH Cost Analysis. Medicaid and the IDPH reimburse Agency cost up to a maximum established rate for the service billed.

Child Health Contract Agencies may not profit from Child Health services provided under Medicaid or Title V. Agencies must bill their actual cost for providing the services, regardless of the maximum reimbursement set by Medicaid or IDPH.

Time Studies

Time Study Requirement

The federal Center for Medicare and Medicaid Services requires that continuous time studies be completed by all staff providing informing and care coordination under the EPSDT *Care for Kids* program. The time studies must be kept on file in each Agency for at least five years.

The time spent working as a front-line staff member for the EPSDT *Care for Kids* program is a primary cost of the program for an Agency. It is very important to consistently document staff time on the Agency's time study form to be sure that all associated costs are captured.

Basis of Cost Reports

Time studies provide information about staffing resources needed to determine an accurate service cost. Time studies help an Agency to:

- Determine actual cost of services
- Provide accountability for services provided
- Determine staffing needs

Time Study Tool

The time study tool is designed to assist Agencies in the development or improvement of local time studies. This tool is located with the Cost Analysis resources on the "Maternal and Child Health Project Management" website here. The tool may be used as it appears or may be altered to meet Agency needs. If an Agency determines the need to modify the template, please contact IDPH at 1-800-383-3826.

Use of Time Studies for Program Monitoring

Time studies are also valuable tools for monitoring program efficiency and studying ways to improve service delivery and staffing patterns. Time studies help administrators to identify what portion of Agency resources are used to provide program services.

A review of the time study can help administrators answer the following questions and make adjustments as necessary.

- Does the staffing pattern provide a quality client-centered service to the client?
- Are all required activities being completed as specified in the Agency protocols from initial contact with the client through documentation and billing?
- How many people are doing the same activity and when is each involved?
- Is the activity being completed in an efficient manner?
- Are qualified people doing the activity?
- Is the Agency providing adequate time for the service?
- Is the Agency using the appropriate staff to meet the needs of the population served (interpreters, ancillary staff)?
- Is the outcome appropriate to the time spent (number of units billed as related to the time spent)?
- Is the staff receiving regular training?

Non-Billable Activities

Many of the activities required for effective informing and care coordination services are not billable. All non-billable activities should be included in the time study in addition to the billable

activities to determine the full cost of informing and care coordination. The following table will help with understanding EPSDT *Care for Kids* informing and care coordination activities that are not billable.

Activity	Description
Maintaining fiscal records	Completing the claims forms and preparing the mailing to the Medicaid fiscal agent. Reviewing denials of original billings and resubmitting the corrected bill. Maintaining fiscal records based on generally accepted auditing procedures.
Maintaining supplies	Managing the paper, brochures, postage and other supplies required for service provision.
Maintain clinical records	Data entry for services provided into CAReS, when provided by the data entry staff.
Managing the computerized list	Downloading data and printing labels and lists for staff to use in their work. This includes downloading information for subcontractors.
Reception	Activity by central service staff to connect clients to the EPSDT *Care for Kids* informing and care coordination staff. Answering the phone, taking messages and making appointments with care coordinator.
Staff travel for other than visits to client	Travel to meetings, contact with community providers, and conferences.
Developing community linkages	Activities to develop and maintain formal and informal linkages between community agencies, providers, and organizations to communicate, coordinate, and plan effective delivery of services.
EPSDT *Care for Kids* administrative meetings	Activities with subcontractors and other staff to plan, communicate, and coordinate the activities of the program.
Continuing education	Activities for staff skill development and education to keep current on policy and best practice.
Administrative activities	Activities related to the management of the EPSDT *Care for Kids* program, including supervising the work of others.
Developing educational materials for clients	Activities to create and maintain brochures, posters and other educational materials for clients.
Development of educational materials for providers and other community resources	Activities to create and maintain brochures, posters, and other educational materials for providers, community agencies, and organizations.
General office work	Activities required of staff to maintain communication and requirements of the organization such as completing reports of activities, filing travel expenses, etc.
Vacation, sick, holiday time	Time given for vacation, holiday, and sick days based on the policies of the organization.

Billing IDPH for Informing Services

Informing services are billed after the initial informing letter is mailed. Billing is completed for the family unit (rather than per client) according to the IDPH Title V contract Agency's cost analysis. The billings for an

informing service includes all activities pertaining to the initial inform, inform follow-up(s), and inform completion. The informing service is not considered complete until direct contact is made with the client (either face-to-face or by phone).

Separating Informing and Care Coordination for Accurate Billing

Often, in the course of completing an informing contact, the conversation changes to linking the client to services. Because these activities are a part of the informing contact, they are considered part of the inform completion. They cannot be billed separately as care coordination.

However, subsequent contacts with the client to link them to services may be billed as care coordination.

Care Coordination Services Allowable for Billing

Activity	Definition
Client contact	Personal telephone, clinic, home visit, or other contact with the client for care coordination services and assessment of needs. Time spent opening the client's chart, preparing content of care coordination service, searching for current phone numbers and addresses.
Identification of needed resources and referral	Activities related to identifying appropriate resources and making referrals for the client as determined in the needs assessment.
Scheduling appointments, transportation, or support services	Activities to set up appointments (outside of the Agency) or make arrangements for transportation to health services or to assist with finding other support services such as interpretation services.
Documentation	Documenting the service provided and other pertinent information directly related to the client's care, including data entry into the CAReS database. This is allowable time only for the care coordinator when entered on the date of service. Data entry into CAReS by a person other than the person who provided the service is not billed as care coordination time.

Billing IDPH for Care Coordination

Care coordination is billed for the total time spent on these activities for the client for each date of service. Time may not be carried over to additional service dates. Time must be accounted for in CAReS and on the time study. Billable care coordination services for a given client when provided by different staff members **on the same day may** be combined for billing.

Care coordination claims are submitted to IDPH for services provided to Medicaid enrolled clients.

Home visits for care coordination are also billed to IDPH for Medicaid enrolled clients. Note that the reimbursement maximum is greater for care coordination in a home visit due to the additional cost incurred for home visits including travel. Do not include travel to and from the home visit in

the care coordination, as that is already part of the higher reimbursement rate.

Care coordination for Title V clients is not billed fee for service to IDPH. Instead, these costs are covered through Title V grant funds.

Submission of Informing and Care Coordination Claims to IDPH

The Iowa Department of Human Services contracts with the Iowa Department of Public Health (IDPH) to provide supervision and financial management for informing and care coordination services. These services are billed to IDPH as fee-for-service. For activities reimbursed on a fee-for-service basis, IDPH reimburses the actual cost of the service, based on the Agency's MCH Cost Analysis, up to an established maximum rate.

Complete Data Entry

To begin the billing process, an Agency must assure that all data entry is completed in the CAReS database system. Data entry must be completed for all services: direct care, informing, and care coordination services provided to the individual client. Once complete, the billing reports in CAReS may be run.

Submitting the Claim

Fee-for-Service (FFS) expenditures billed to the Department, must be submitted monthly, within 45 days following the month of service.

- Documentation for CH FFS activities must be entered in CAReS by the 15th of the month following the month of service. CAReS documentation will be pulled automatically by IDPH.
- At the end of the state fiscal year, documentation timelines are more stringent. Documentation for all FFS activities must be entered by end of the first week in July for all services provided through June 30. Monthly claims for services provided through June 30 must be submitted no later than mid-July. Claims submitted after this timeframe will not be paid. See the MCH Contract for specific dates.

Claims Review

In addition to supervision and financial management, IDPH also ensures that payments to Contract Agencies on behalf of Medicaid-eligible clients are reasonable and maintain standards for quality. As such, services will be reviewed according to quality assurance measures prior to payment. CAReS billing reports have built in quality assurance controls; however, Agencies should review reports to determine that services are entered accurately and completely in CAReS.

Errors identified by the quality assurance process will be shared with the Agency for correction prior to payment

Questions?

Questions regarding billing informing and care coordination can be

submitted to Medicaid fee-for-service staff within the BFH at 1-800-383-3826.

Submission of Direct Care Claims to Medicaid (IME)

When providing direct care services, Child Health Agencies must follow the guidelines for Medicaid Screening Centers found on the Iowa Department of Human Services website at http://dhs.iowa.gov/policy-manuals/medicaid-provider. For a complete listing of direct care services available under the EPSDT *Care for Kids* program, see the Child Health Services Summary.

Claims for direct care services are submitted to the Iowa Medicaid Enterprise (IME) using the CMS 1500 form. A complete listing of billing codes for EPSDT direct care services is found in the Medicaid Screening Center Provider Manual. Maximum reimbursement rates are located on the Iowa Medicaid Enterprise website at http://dhs.iowa.gov/policy-manuals/medicaid-provider. See Fee Schedules Index for Screening Centers.

Child Health Agencies bill their cost as determined by the Agency's MCH Cost Analysis. Clients must be eligible for Medicaid on the date the service was provided. Claims must be submitted within one year of the date of service. For quick turnaround, claims may be submitted electronically.

Electronic Submission

Contact the Medicaid fiscal agent for information on the electronic billing software package (known as PC-ACE Pro 3). This billing software is provided at no charge to the Agency. See http://dhs.iowa.gov/policy-manuals/medicaid-provider. Electronic billing is conducted through the Electronic Data Interchange (EDISS).

The IME Electronic Funds Transfer (EFT) form is available online to download, complete, and mail to IME. Go to http://dhs.iowa.gov/ime/providers/forms to download the EFT form 470-4202.

Hard Copy Submissions:

If hard copies of the CMS 1500 are submitted, send forms to:

Medicaid Claims
P.O. Box 150001
Des Moines, IA 50315

Denial of a Claim:

Claims that are denied may be resubmitted to the fiscal agent with corrections up to one year after the initial denial of the claim. Documentation to support direct care services must be in the CAReS database and client chart.

Chapter 7 Appendices

Chapter 8 Agency Protocols

Chapter 9 IME Updates